OLDMUTUAL

GROUP ASSURANCE INCOME PROTECTION APPLICATION PACK

(Also for use for lump sum disability benefits)

TAKING YOUR LIFESTYLE BACK STARTS HERE...

BECAUSE LIFE DOESN'T ALWAYS HAPPEN AS PLANNED

IMPORTANT:
Go through this document **together** with Human Resources and make sure you understand all your benefits.

INSTRUCTIONS FOR THE EMPLOYEE

1 Have you exhausted all your options?

These include:

a) Consult with a GP/Specialist ☐
b) Consult with a psychologist/psychiatrist ☐
c) Change of your job tasks ☐
d) Reduced capacity employment ☐
e) Ask your employer to make adjustments in the workplace ☐
f) Consider alternate occupation ☐

2 You've worked hard. So let us take care of the financial stress, while you get better.

Within one month of not being able to work, submit a claim form. Old Mutual is here to make your recovery easier by giving you financial peace of mind for the weeks that you are unable to work.

3 Here's what to do next:

- **Speak to HR to go over your benefits**
- **Detach pages 1 to 4 to use as a guide while you complete this form**
- **Study the Income Protection Guide for more detail**

4 You're on your way to recovery!

Most of our members recover successfully within a few weeks. We are here to help you through all the steps necessary for you to get your health and financial independence back.

Email gapdisabilityassessments@oldmutual.com or speak to your HR person if you have further questions.

Your to-do list before handing in this form

	Tick here when action is complete ✔
1) Go through your **benefits with HR** including: a) The potential value of income you will receive if your claim is valid b) The duration of your income protection and your waiting period c) How your employer will aid your return to work d) Outline **3 return to work goals** that you can do e.g. "daily exercises before breakfast" e) Study the income protection guide	
2) Ask HR to explain the **benefits that you will not receive** from your employer during the income protection period	☐
3) Hand in **all necessary documents** as outlined on page 3	☐

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NECESSARY DOCUMENTS TO FILL IN:

- **You (employee) fill in sections 1 and 2** (7 pages)
- Your employer fills in sections 3, 4 and 5 (8 pages)
- Your GP/Specialist fills in section 6 (3 pages)

INFORMATION TO COMPLETE THIS APPLICATION PACK

INSTRUCTIONS FOR THE EMPLOYER to review with the employee

GUIDELINES FOR COMPLETING THIS FORM

1. Fill in all the information on the claim, we can process information quicker this way.
2. Print, stamp and sign the form if you are completing it electronically, then scan and email it to us.
3. We encourage you to send the employee's claim to us as close to the start of their absence from work as possible. Your employee may benefit from the early medical treatment and assessment of their claim.
4. Please send us the claim **as soon as you intend to submit**. The maximum period for which we'll accept a submission is within 12 months of the employee's date of absence from work. If the claim is sent after this time, it may be declined due to late submission.
5. We check that the monthly premiums for the employee were paid while they were working and after they were absent from work. Not paying these premiums means the claim will not be valid.
6. Do you have all the necessary documents to submit this application? Use the checklists below to assist you.

IMPORTANT:
Attach all relevant documents based on the list below, then tick them off as you have done so.

1. FORMS THAT WE ALWAYS NEED (REQUIRED TO START THE ASSESSMENT OF THE CLAIM)	WHOSE RESPONSIBILITY	✓
Completed and signed employee application (Section 2)	Employee	
Completed and signed employer application (Section 3)	Employer	
Copy of the employee's identity document (and marriage certificate if the employee's surname has changed)	Employee	
Comprehensive medical report from the treating medical practitioner/GP (Section 6)	Employee	
Employee payslips for 3 months, two from before the absence from work and one from after (please include the total guaranteed package/total cost to company)	Employee	

2. ADDITIONAL DOCUMENTS THAT MAY BE REQUIRED DURING THE CLAIMS ASSESSMENT PROCESS. (THESE DOCUMENTS ARE ALWAYS REQUIRED IF THE EMPLOYEE'S DATE OF ABSENCE IS UNCLEAR)	WHOSE RESPONSIBILITY	✓
Medical certificates	Employee	
Copies of special medical investigations	Employee	
Sick leave records	Employer	
Productivity report (Section 5)	Employer	
Job description or Employment contract	Employer	

3. ADDITIONAL DOCUMENTS REQUIRED IF THE EMPLOYEE IS A COMMISSION EARNER	WHOSE RESPONSIBILITY	✓
12 months' payslips prior to the date of absence (or 36 months if indicated in your policy document)	Employer	

4. ADDITIONAL DOCUMENTS REQUIRED FOR PAYMENT OF A VALID CLAIM	WHOSE RESPONSIBILITY	✓
If benefits are being paid to employer for the first time: Employer banking details on the bank letterhead OR	Employer	
If benefits are payable to the employee: Direct payment to the employee form (Section 4)	Employer	
Cash4♥Ones Nomination form (Section 2)	Employee	

SEND THE COMPLETED DOCUMENTS TO US:

Our website **oldmutual.co.za/corporate/forms-and-downloads** contains our claim requirements, as well as useful information and guides to assist you through the claims process. You may also call our HR 911 helpline on 021 509 3911 for any assistance with the claims process.

Email GAPDisabilityAssessments@oldmutual.com
Fax 021 509 6855

Post Old Mutual Group Assurance Claims
PO Box 1659
Cape Town 8000
South Africa

PROTECTION OF PERSONAL INFORMATION DISCLOSURE

The Old Mutual Group would like to offer you ongoing financial services and may use your personal information to provide you with information about products or services that may be suitable to meet your financial needs. Please sms your ID number to 30994 if you would prefer not to receive such information and/or financial services.

The personal information received by Old Mutual in accordance with this contract will be used, as and when appropriate, for the following purposes:

- Underwriting
- Assessment and processing of claims
- Claims checks (Life and Claims Register)
- Fraud prevention and detection
- Tracing beneficiaries
- Audit and record keeping purposes
- Compliance with legal and regulatory requirements
- Verification of the personal information provided

Personal Information will be de-identified when used for market research and statistical analysis.

When Old Mutual engages service providers to process personal information on its behalf or to render services to it, Old Mutual may share some personal information with these service providers, subject to confidentiality agreements being in place between Old Mutual and such service providers. Should these service providers be abroad, Old Mutual will not share the personal information with them unless it is satisfied that adequate security measures are in place to protect the personal information.

The Policyholder is advised and encouraged to inform all members/lives assured that Old Mutual holds and is processing their personal information for the purposes noted above. The Policyholder or a member/life assured may access the personal information relating to him or her and, subject to the provisions this contract may request the correction of any errors or the deletion of this information. In certain cases the Policyholder and members/lives assured have the right to object to the processing of their personal information.

You also have the right to complain to the Information Regulator, whose contact details are:
Tel 012 406 4818
Fax 086 500 3351
Email inforeg@justice.gov.za
Website **justice.gov.za/inforeg/index.html**
To view our full privacy notice and to exercise your preferences, please visit our website on **oldmutual.co.za/privacy-policy/**

APPLICATION FOR INCOME PROTECTION 1

SECTION 1: **EMPLOYEE APPLICATION** (to be completed by the employee)

Most members with a successful claim recover within 12 weeks

Our claims team has many years of experience and we take pride in helping you during a time when support is key.

With our support, most members with a successful claim recover successfully, within 12 weeks.

In order for us to do the same for you and help you on your journey to recovery, please assist us by completing all questions below.

DECLARATION BY THE EMPLOYEE

You declare and authorise us to obtain and share personal health information:

I, _____, declare that the information provided by me is true and correct, and that I have provided complete answers.

If you are unable to sign this form, a next of kin can sign on your behalf and can send us an affidavit confirming the relationship and the reason that you are unable to sign the application form.

A NOTE ON FRAUD
By signing this document, you acknowledge that submitting a false claim is a criminal offence and can result in fines and/or imprisonment.

1.1 PERSONAL INFORMATION

Surname

First name(s)

Gender: Female Male Preferred language

Physical address

Postal code

Postal address (if different from above)

Postal code

Telephone number Cellphone number

Personal email address

When did you last work?

D D M M Y Y Y Y Any extra details?

When did you last receive a salary from your employer?

D D M M Y Y Y Y Any extra details?

1.2 TELL US ABOUT YOUR EDUCATION AND TRAINING

FILL IN ALL COMPLETED EDUCATION		YEAR
Matric	YES ___ NO ___	
Highest grade passed		
Diploma	YES ___ NO ___	
University degree(s)		

1.3 TELL US ABOUT YOUR WORK EXPERIENCE HISTORY INCLUDING YOUR CURRENT JOB

YEARS WORKED	EMPLOYER	MAIN DUTIES

Answer the next section by following the flow of the diagram, ticking and filling in boxes where appropriate.

1.4 TELL US ABOUT YOUR CAREER

A. Before your disability, **how hard would you say you worked** compared to others around you?

(10 being the hardest)

1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___ 9 ___ 10 ___

TICK THE STATEMENTS WITH WHICH YOU AGREE.

B. My work helps me with the following...

___ Finance my hobbies

___ Support my family

___ Keep my brain active

___ Improve my social life

1.5 TELL US ABOUT YOUR CAREER (continued)

C. Have you discussed a return to work plan with your employer?

YES ☐	NO ☐
☆ **Well Done!** **You're thinking ahead and making active steps to recovery.**	If you haven't discussed a return to work plan, **please tell us about your plans for employment once you have recovered**, in the box below.
In how many weeks do you plan on returning to work?	
On what date have you agreed to return to work? D D M M Y Y Y Y	
Sign here:	
Tell us more about your return to work in terms of:	
How often do you plan on checking-in with your employer? Every _____ days	
To support your return to work, list 3 specific actions that you plan on taking:	
Action 1 — e.g. I will walk for 30 minutes on a Tuesday and Thursday before dinner	
Action 2 — e.g. I will contact my manager every Monday	
Action 3	

D. How motivated are you to return to work?

HIGH MOTIVATION ☐	LOW MOTIVATION ☐
	How can Old Mutual/your employer assist you in improving your motivation?
Keep it up!	

E. When you recover, what do you look forward to doing the most?

F. Have you been involved in part-time or other work while at your current job? Was this work paid or unpaid?

G. What other work are you interested in exploring in order to earn an income?

1.6.1 TELL US ABOUT THE ACTIVITIES YOU DO WHEN YOU HAVE FREE TIME

I enjoy and can do the following hobbies, exercises or activities:

I would like to do more of:

If there is one thing I wish I could do, it would be:

1.6.2 TELL US ABOUT YOUR ABILITIES

Given your illness, tell us which of the below you can do).

ACTIVITY	ON MY OWN	WITH SOME HELP	WITH A LOT OF HELP	ANYTHING ELSE TO TELL US?
Bathing, dressing, toileting				
Eating & food preparation				
Walking, standing, sitting				
Bending, lifting, carrying				
Childcare				
Banking				
Grocery shopping				
Household tasks				
Driving a car				
Catching a bus/train/taxi				

Describe the symptoms you are currently experiencing? How does it affect your work?

Is there anything at the workplace that led to your absence? If yes, explain...

Is there anything at the workplace that can change in order to allow you to return to work?

1.7 AUTHORISATION BY THE EMPLOYEE

AUTHORISATION

You declare and authorise us to obtain and share personal health information:

I, _____ , expressly consent and authorise Old Mutual:

a) to obtain from any medical practitioner, health professional, hospital, Life and Claims register, employer, insurer, medical scheme and any other person who or institution which may be in possession of, or later acquire, any information concerning my health, occupation, earnings and insurance cover, and

b) to share this information with other parties, health professionals (including employee wellness programmes), the employer, fund, ombudsman, legal representatives or other insurers if necessary, for the purpose of the assessment or review of my disability claim and for return to work rehabilitation purposes.

I agree that Old Mutual may use the personal information provided to them in order to verify my identity and check the validity of my claim and to detect and prevent fraud.

I agree that Old Mutual may further use and keep my personal information for historical, statistical, compliance with legal or regulatory requirements and for research purposes, subject to the provisions in the Protection of Personal Information Act 4 of 2013.

I understand that my right to privacy is curtailed to the extent permitted by me in this authorisation. I understand that Old Mutual needs this information to facilitate the assessment and review of my claim under a group policy.

INDEMNITY

I indemnify Old Mutual South Africa and any entity that forms part of the Old Mutual Group of companies, including but not limited to any director, employee or agent of these entities and hold them harmless against any claim, loss or damage arising as a result of:

a) a breach of my personal information (including information relating to my health, occupation and earnings) by any medical practitioner, health professional, my employer, fund or other insurer sent to them by Old Mutual with my consent for the purposes of assessment, review or for return to work rehabilitation purposes in relation to my disability claim.

b) their identification, assessment and recommendation concerning the treatment I receive from Old Mutual in order to assist me with my rehabilitation.

c) the medical evaluation, advice, and treatment I receive from any medical practitioner or health professional to whom Old Mutual has referred me.

d) Incorrect, inaccurate or insufficient medical information provided to us which we have in turn passed to any medical practitioner or health professional for evaluation, advice or treatment relating to my disability.

Surname	
First name(s)	
Identity number	
Date	D D M M Y Y Y Y
Your signature	

1.8 FRIEND OR FAMILY CONTACT DETAILS (in case we cannot get hold of you)

Surname	
First name(s)	
Relationship to you (employee)	
Telephone number	Cellphone number
Email address	

1.9 IF YOU HAVE OTHER DISABILITY INSURANCE, COMPLETE THIS SECTION

Complete this question if you have other disability insurance policies.

Insurer		Policy number	
Insurer		Policy number	

1.10 TELL US ABOUT HOW YOU USE HEALTH SERVICES

WHERE DO YOU GO FOR HEALTHCARE? PLEASE TICK ALL THE APPLICABLE OPTIONS.

☐ Private healthcare ☐ State hospitals and clinics ☐ Alternative medicine ☐ Traditional healer

Name of medical aid | Membership number

When did you first consult a doctor for your current medical condition? D D M M Y Y Y Y

KEEP IT UP!
If you have completed section 1, you are one step closer to getting your health back on track and taking back your lifestyle.

NOMINATION FORM FOR THE CASH4♥ONES BENEFIT 2

SECTION 2: **NOMINATION FOR THE CASH4♥ONES BENEFIT** (to be completed by the employee)

GUIDELINES FOR THE EMPLOYEE

In the unfortunate event of your death, we will support your loved ones with a Cash4♥ones benefit. You nominate one person to receive this benefit when you pass away. To be covered for this benefit, you need to complete the Waiting Period and your monthly income claim needs to be accepted.

1. Please complete and sign this form to inform Old Mutual who should receive this benefit. If we do not have complete beneficiary details, the benefit will be paid to your Estate via your bank account.
2. The death certificate and the beneficiary's Identity Document need to be submitted in order for the benefit to be paid.

2.1 YOUR DETAILS

Surname

First name(s)

Identity number

BANKING DETAILS

Name of bank

Branch code Account number

Type of account: ___ Cheque ___ Savings ___ Transmission

2.2 CASH4♥ONES BENEFICIARY DETAILS

If there are no details here, the benefit will be paid to your Estate via your bank account. We will pay to the beneficiary if they are older than 18 years.

Surname

First name(s)

Relationship

Identity number

Address

Postal code

Email address

BANKING DETAILS

Name of bank

Branch code Account number

Type of account: Cheque Savings Transmission

CONTACT DETAILS

Telephone number (work)

Telephone number (home)

Cellphone number

Signature of employee Date D D M M Y Y Y Y

APPLICATION FOR INCOME PROTECTION 3

SECTION 3: **EMPLOYER APPLICATION** (to be completed by the employer)

TICK WHEN COMPLETE

IMPORTANT: Does the employee understand the benefit that they will receive should their claim be successful? ☐

Have you developed a return to work plan with the employee? ☐

GUIDELINES FOR THE EMPLOYER

1. If you provide us with complete and accurate information, we are better able to pay valid claims.
2. Are you in an officially recognised position at the employer in order to sign these forms? Please complete the employer declaration.

DECLARATION BY THE EMPLOYER

I, _____ the undersigned, in my capacity as _____ and duly authorised to make this declaration as the employer, hereby declare that the information I provide in this claim is true and correct, and that no information is omitted or withheld.

I indemnify Old Mutual Group Assurance against any claim that may arise from any incorrect information provided in this form.

Full name

Contact number

Email address

Signature

Date D D M M Y Y Y Y

3.1 EMPLOYER DETAILS

3.1.1 SCHEME DETAILS

Scheme name

Employer name

3.1.2 EMPLOYER DETAILS

Contact person

Designation

Contact number

Email address

Physical address

Postal code

Employee's line manager

Contact number

3.1.3 YOU ARE SUBMITTING THE CLAIM FOR:

Employee's surname

Employee's first name(s)

Employment status: ☐ Permanent ☐ Contractor ☐ Terminated ☐ Resigned Employee number

Date employee started at company D D M M Y Y Y Y Date employer joined the fund D D M M Y Y Y Y

Date employee joined the fund D D M M Y Y Y Y

Normal retirement age

3.1.4 EMPLOYEE JOB DESCRIPTION

Job title | Year started in current role

What are the **main tasks** that the employee must perform?

WHAT IS THE % OF TIME SPENT PERFORMING ANY OF THE FOLLOWING CONDITIONS	
Administrative	
Manual/handling machinery or equipment	
Commercial work (buying/selling)	
Supervision or inspection	
Driving	
Other duties, please specify:	

What **environment** does the employee spend most time in?

WHAT IS THE % OF TIME SPENT PERFORMING ANY OF THE FOLLOWING ENVIROMENTAL CONDITIONS	
Exposure to weather • Extreme cold • Extreme heat • Wet and/or humid	
Noise intensity level	
Exposure to radiation	
Vibration	
Working in high exposed places	
Working with explosives	
Exposure to toxic or caustic chemicals	
Proximity to moving mechanical parts	
Exposure to electric shock	
Atmospheric conditions	
Other environmental conditions	

3.1.5 EMPLOYEE WORK PERFORMANCE

Is the employee currently absent from work? YES NO

If "Yes":

- When did the employee's continuous absence from work begin? D D M M Y Y Y Y
- When is the employee expected back at work? D D M M Y Y Y Y

If "No":

- When was the employee last able to perform all of their normal duties? D D M M Y Y Y Y

Please complete a productivity report.

- Are there work related issues that led to this absence from work? YES NO
- Did you experience any performance management issues before the absence? YES NO

Tell us about it

How did the employee perform in their job **before** the onset of their health condition?

How did the employee perform in their job **after** the onset of the condition?

What accommodations have been made to assist the employee, e.g. changes to the employee's duties, work hours, environment or equipment used?

Did you discuss a plan for return to work?

What accommodations, if any, are planned for the future?

3.1.6 OCCUPATIONAL INJURIES AND DISEASES

The **insured** claims process is separate to the **injury on duty** process.

Has the employee been injured on duty or developed an occupational disease? YES NO

Has a claim been submitted to COID? YES NO

If "Yes", please supply details of the workman's compensation, injury, illness or accident.

3.1.7 EMPLOYEE INCOME DETAILS

Employee tax number

Please supply the Total Guaranteed Package Salary/Total Cost to Company in order to calculate the tax in respect of the Group Income Protection benefit. R

During which month is the annual salary increase granted?

What was the employee's basic annual income for the previous three years? 20_____ , R

20_____ , R

20_____ , R

If the employee received an annual increase of 15% or above, please provide a reason and supporting documentation.

Did the employee receive an increase after absence from work began? YES NO

If "Yes", when? D D M M Y Y Y Y

DISABILITY BENEFITS PAID DIRECTLY TO THE EMPLOYEE 4

SECTION 4: **EMPLOYEE DETAILS** (to be completed by the employer)

GUIDELINES FOR THE EMPLOYER

1. The employer completes this form if the benefit should be paid directly to the employee. If the benefit is approved, our benefit payments are usually made on the 25th of the month.
2. We will be better able to process the benefit payment when you complete this document accurately. If any information has been omitted, or is incorrectly completed, Old Mutual will not be held responsible for errors as a result.
3. You are welcome to contact us at 0860 10 36 59 if you are unsure about any aspect of completing this form.

4.1 DECLARATION BY EMPLOYER

I have provided complete and accurate information and do not hold Old Mutual responsible for information that has been withheld or omitted.

Surname

First name(s)

Designation

Telephone number

Signature

Date D D M M Y Y Y Y

Scheme name

Scheme code

Employee number

4.2 REFUND DISABILITY BENEFIT TO THE EMPLOYER FOR PAYMENTS AFTER THE WAITING PERIOD

If the claim is valid, and the employer pays the employee after the waiting period, Old Mutual will pay the benefit due to the employer. We pay the benefit value due and not any other payments made (excluding sick leave and annual leave payments).

Employer registration number

Telephone number

Email address

The date the employer last paid the employee D D M M Y Y Y Y

Full month's salary? YES NO

Please indicate the date from which Old Mutual should begin paying the employee directly? D D M M Y Y Y Y

EMPLOYER'S BANKING DETAILS

Name of account holder

Name of bank

Branch name

Branch code

Account number

Account type Cheque Savings Transmission

4.3 EMPLOYEE DETAILS

PERSONAL INFORMATION

Surname

First name(s)

Identity number

Physical address

Postal code

Postal address
(complete if different
to postal address)

Postal code

Contact number during the day

Email address

EMPLOYEE'S BANKING DETAILS

Name of
account holder

Name of bank

Branch name

Branch code

Account number

Account type ☐ Cheque ☐ Savings ☐ Transmission

EMPLOYEE'S CONTRIBUTION TO THE EMPLOYER RETIREMENT FUND

Please indicate whether an employee contribution must be deducted from the monthly benefit and paid to the Retirement Fund:

☐ YES – an employee contribution must be deducted

☐ NO

If "Yes", employee contribution to the Retirement Fund ☐☐ % of salary

(Please supply the banking details for the fund on the bank's letterhead.)

OTHER DEDUCTIONS TO BE MADE FROM THE EMPLOYEE'S BENEFIT

Old Mutual is only able to pay fund and employer-related deductions (e.g. pension, housing loans, medical aid, funeral schemes and garnishee orders.)
All personal policies deducted by the employer must be paid by the employee via debit order.

4.4 DETAILS OF DEDUCTIONS FOR EMPLOYEE

If there are more than 2 deductions, please make a copy of this page and complete.

DEDUCTION 1

Deduction description

Organisation name/fund

Amount to be deducted

Number of dependants in respect of medical aid contributions

Date deduction must start D D M M Y Y Y Y Date deduction must be stopped D D M M Y Y Y Y

Reference number

Contact person

Telephone number

Email address

Name of account holder

Name of bank

Branch name Branch code

Account number

Account type Cheque Savings Transmission

DEDUCTION 2

Deduction description

Organisation name/fund

Amount to be deducted

Number of dependants in respect of medical aid contributions

Date deduction must start D D M M Y Y Y Y Date deduction must be stopped D D M M Y Y Y Y

Reference number

Contact person

Telephone number

Email address

Name of account holder

Name of bank

Branch name Branch code

Account number

Account type Cheque Savings Transmission

PRODUCTIVITY REPORT 5

SECTION 5: **EMPLOYEE DETAILS** (to be completed by the employer)

GUIDELINES FOR THE EMPLOYER

1. The employee's direct line manager or supervisor can complete this questionnaire.
2. The questions below are a guideline only, you can provide us with all relevant information on the employee's work performance in a typed report or a separate sheet where necessary.
3. Please complete the attached rating form regarding the employee's work habits and tolerance.

We appreciate your comprehensive feedback. Thank you for your assistance.

5.1 EMPLOYEE DETAILS

Name of employee	
Name of employer	
Position employee holds	
Date employed in this position	D D M M Y Y Y Y

5.2 TO BE COMPLETED BY THE EMPLOYER

PLEASE ANSWER THE FOLLOWING	
1. Since when has the employee experienced difficulties at work? Please describe these difficulties.	D D M M Y Y Y Y
2. How would you describe the employee's work performance prior to this.	
3. Please describe any other workplace factors that may have contributed to this change in performance.	
4. What duties are/were the employee not performing? Please provide the reasons for this, as well as the approximate date when they stopped performing these duties.	D D M M Y Y Y Y
5. Have there been any changes in terms of the number of hours a day or week the employee is/was able to work? Please explain and provide approximate dates of changes.	D D M M Y Y Y Y
6. Have any other alternative jobs or accommodations been considered or tried? Please provide the date that alternative duties or accommodations started.	D D M M Y Y Y Y
7. Please indicate how the employee is/was coping with these duties e.g. productivity levels, accuracy of work? Please estimate the percentage of the job that they are not performing (%).	
8. Any other comments. Please continue on a separate sheet if necessary.	

PRODUCTIVITY RATING

Please rate the employee on all of the criteria provided below. Mark the appropriate value with an "X".

Please provide examples and support your rating with the appropriate comments.

Key: 5 = Excellent 4 = Above average 3 = Average 2 = Below average 1 = Poor/unacceptable

	1	2	3	4	5	Comments
Attendance						
Punctuality						
Concentration and attention (ability to focus on the task at hand)						
Memory (ability to remember instructions and how to perform tasks)						
Relationships/communication with clients						
Relationships/communication with colleagues						
Relationship/communication with supervisor						
Ability to handle stressful situations						
Problem solving						
Ability to work a full day/shift						
Ability to utilise the tools and equipment of the job appropriately and safely						
Ability to perform the mobility related components of the job e.g. standing, walking						
Ability to perform other physical components of the job e.g. bending, lifting, carrying, stooping, kneeling						
Ability to perform aspects of the job requiring the use of both arms and hands						
Ability to perform aspects of the job requiring vision and hearing						
Other comments						

Signature

Print name

Designation

Telephone number

Date D D M M Y Y Y Y

MEDICAL REPORT 6

SECTION 6: **EMPLOYEE DETAILS** (to be completed by the medical practitioner)

GUIDELINES AND IMPORTANT INFORMATION FOR THE TREATING MEDICAL PRACTITIONER

1. To assess and manage occupational disability claims, Old Mutual needs updated medical information from the patient's healthcare provider(s).
2. Please complete the questionnaire by hand, writing as legibly as possible, or compile a typed report that includes all the aspects covered in this questionnaire.
3. Please attach copies of test results that confirm the diagnosis.
4. The patient is responsible for the cost of this examination and report.
5. Detailed information and your prompt submission will help your patient in their claim application by assisting us to process the claim efficiently.

Thank you for your assistance.

IMPORTANT:
Complete and send **within 5 days** of seeing the patient.

6.1 PATIENT DETAILS

Surname	
First name(s)	
Identity number	
Date of birth	D D M M Y Y Y Y

6.2 TO BE COMPLETED BY THE MEDICAL PRACTITIONER

Please provide the medical history.

Describe your current clinical findings.

Please describe the results of any investigations done, including dates.

Diagnosis, with staging if relevant.

Date first consulted for this diagnosis D D M M Y Y Y Y

ICD10 code

Please tell us more about their functional ability.

ACTIVITY	ON THEIR OWN	WITH SOME HELP	WITH A LOT OF HELP	ANYTHING ELSE TO TELL US?
Bathing				
Dressing				
Toileting				
Eating & food preparation				
Walking				
Standing				
Sitting				
Bending				
Lifting				
Carrying				

TREATMENT

Please describe the treatment of the patient.

MEDICATION USED	DOSAGES	DURATION	EFFECTIVENESS

Admissions to hospital: duration, reason for admission, and treatment.

DATE OF ADMISSIONS TO HOSPITAL	DATE OF DISCHARGE	REASON FOR ADMISSION	TREATMENT

Other health professionals on the team, e.g. occupational therapy, physiotherapy, speech therapy, etc.

Is the patient compliant with treatment? If not, please explain.

Is this treatment optimal? If not, what are the obstacles experienced?

What future health management is planned or considered ideal?

What is the prognosis?

When will the patient no longer be impaired by this condition?

When can the patient perform the functions of their job? D D M M Y Y Y Y

Is the patient capable of working part time? Please explain.

What is the patient's motivation to return to work?

Are there other issues at work which could contribute to the patient's absence?

6.5 REPORTING DOCTOR

Initials and surname

Speciality

HPCSA number

Practice number

Telephone number

Date D D M M Y Y Y Y

Signature